

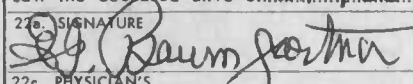
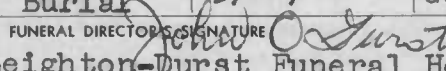
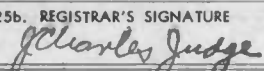
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03786

03786

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Garrett</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural - Oakland</b> c. LENGTH OF STAY IN 1b <b>Lifetime</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Star Route</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Oakland - Rural</b> d. STREET ADDRESS <b>Star Route</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>JOHN ALVIN CASTEEL</b>		<b>4. DATE OF DEATH</b> <b>March 15, 1966</b>		<b>5. SEX</b> <b>Male</b>			
<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>July 18, 1890</b>			
<b>9. AGE</b> (In years last birthday) <b>75</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Lumberman</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Garrett Co., Maryland</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>John William Casteel</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Rebecca Louise DeWitt</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Mrs. Darvin Reckart, Oakland, Md.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADAMS-STOKES SYNDROME</b> 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIO SCLEROSIS</b>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from 2/17/62, 19, to 3/15/66, 19, that (I) (we) last saw the deceased alive on 3/15/66, 19, and that death occurred at 3:30 P.M. from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> 		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>3-16-66</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>E.I. Baumgartner, M.D.</b>		<b>22d. ADDRESS</b> <b>Oakland, Maryland</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>3/18/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Garr.Co.Mem.Gardens</b>			
<b>23d. LOCATION (City, town or county)</b> <b>Oakland, Maryland</b>		<b>(State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> 		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 21 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

03787

03777

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Garrett Alleg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Grantsville</b>				c. LENGTH OF STAY IN 1b <b>4 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Goodwill Mennonite Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Maud</b> Last <b>Chaney</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>19 66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 10, 1872</b>	
9. AGE (In years last birthday) <b>93</b> yrs.		10. IF UNDER 1 YEAR Months <b>93</b> Days <b>0</b> Hours <b>0</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>John Long</b>				14. MOTHER'S MAIDEN NAME <b>Clarissa Martin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Earl D. Chaney</b>	
15. Address <b>832 Windsor Rd Cumberland, Md</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic brain syndrome</b> ) <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Circulatory disturbance</b> ) (c) <b>Cerebral arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>  <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 19 62</b> to <b>March 30, 19 66</b> that I last saw the deceased alive on <b>March 29, 19 66</b> , and that death occurred at <b>4:50 P. M.</b> from the causes and on the date stated above.							DATE SIGNED <b>3/31/66</b>
ACTUAL SIGNATURE <b>A. Paige Strong</b>		M.D. <b>Grantsville, Md.</b>					
PHYSICIAN'S NAME (Type) <b>A. Paige Strong</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/1/66</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>				ADDRESS <b>Cumberland Maryland 21502</b>		24a. REC'D BY REGISTRAR <b>APR 4 1966</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03788

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03778

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendsville (Rural)</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendsville (Rural)</u> // - 1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jeffrey Allen Fearer</u>				4. DATE OF DEATH Month Day Year <u>March 8th.</u> 19 <u>66</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 2, 1965</u>	9. AGE (In years last birthday) yrs. <u>11</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) <u>Oakland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest Fearer</u>				14. MOTHER'S MAIDEN NAME <u>Madeline Rosenberger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address <u>Ernest Fearer, Friendsville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of Stomach Contents</u> 5710 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Gastroenteritis and dehydration</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN DEATH AND DEATH <u>Minutes</u> <u>Days</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> M.D. EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <u>Oakland, Md.</u>			
22. DATE SIGNED <u>3-8-66</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/11/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Blooming Rose Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Friendsville, Garrett, Md.</u>	
24. FUNERAL DIRECTOR <u>Don Newman</u>				ADDRESS <u>Grantsville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 14 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03789					03779						
1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Oakland</b> c. LENGTH OF STAY IN 1b <b>19 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Garrett Co. Memorial Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b> d. STREET ADDRESS <b>323 N. 4th Street,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Letha</b> Middle <b>Virginia</b> Last <b>Feather</b>			4. DATE OF DEATH Month <b>March</b> Day <b>25th</b> Year <b>1966</b>								
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-10-1883</b>		9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Grant Co., W. Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Charles Stewart</b>					14. MOTHER'S MAIDEN NAME <b>Mary ?</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>236-14-5170D</b>		17. INFORMANT <b>Merritt Feather, Oakland, Md.</b> Address <b>(son)</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> 331X DUE TO (b) <b>Arteriosclerosis, generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> , 19 <b>3-25-66</b> , to <b>3-25-66</b> , 19 <b>3-25-66</b> , that (I) <b>was</b> last saw the deceased alive on <b>3-25-66</b> , 19 <b>3-25-66</b> , and that death occurred at <b>6:10 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>James H. Feaster, Jr., M.D.</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-25-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>James H. Feaster, Jr., M.D.</b>					22d. ADDRESS <b>104 S. 2nd. St., Oakland, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3/28/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mill Creek Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Mill Creek, W. Va.</b>			
24. FUNERAL DIRECTOR <b>Leighton-Durst</b> ADDRESS <b>Leighton-Durst Funeral Home, Oakland, Md.</b>					25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				
DATE <b>MAR 28 1966</b>											



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
03790					CERTIFICATE OF DEATH					03780				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					Reg. Dist. No.				
a. COUNTY <u>Garrett</u> MARYLAND					a. STATE <u>Md.</u> b. COUNTY <u>Garrett</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>					c. LENGTH OF STAY IN 1b <u>11 Mo.</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Friendsville</u> // - /				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakrest Nursing Home</u>					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Louise Kathryn Friend</u>					4. DATE OF DEATH <u>March 5,</u> 19 <u>66</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 11, 1892</u>		9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
										Months		Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>					11. BIRTHPLACE (State or foreign country) <u>Garrett Co., Md.</u>				
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					13. FATHER'S NAME <u>William Brown</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Bowser</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>—</u>					INFORMANT Address <u>Mr. Fred Friend, Friendsville, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>4221</u> DUE TO Arteriosclerotic cardio-vascular disease. Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> Years _____				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____				
					20f. (City or town) _____ (County) _____ (State) _____									
21. I certify that I attended the deceased from <u>April 3-5-66</u> , 19 <u>65</u> to <u>3-5-66</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>3-5-66</u> , 19 <u>66</u> , and that death occurred at <u>8:15P</u> M, from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <u>104 S. 2nd. St. Friendsville, Md.</u> DATE SIGNED <u>3-7-66</u>				
ACTUAL SIGNATURE <u>[Signature]</u> M.D.					PHYSICIAN'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u>					Oakland, Maryland 21550				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>3/8/66</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Blooming Rose Cem.</u>				
					22d. LOCATION (City, town, or county) <u>Friendsville, Garrett, Md.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>					ADDRESS <u>Grantsville, Md.</u>					24a. REC'D BY REGISTRAR <u>MAR 9 1966</u>				
										24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

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RECEIVED



10750

Arteriosclerotic cardio-vascular disease.  
Coronary vascular disease.

1-2-66

8:15P

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1-2-66

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03791					03781				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				
Garrett MARYLAND					Maryland Garrett				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Oakland			57 days-10 hrs.		Shallmar				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
Garrett County Memorial Hospital					Main St.				
3. NAME OF DECEASED (Type or print)			First Middle Last		4. DATE OF DEATH		Month Day Year		
Nettie Lavina Hanlin					March 24,		19 66		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		May 10, 1895		70 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
Housewife			Own Home		Midlothian, Maryland			U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Benjamin Wilson				Mary Winebrinner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT			
No				212-24-8710		Harrison T. Hanlin, Kitzmiller, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Cardiac vascular Disease</i> 443x DUE TO (b) <i>Atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
INTERVAL BETWEEN ONSET AND DEATH 10 yrs 15 yrs									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 25, 1966, to March 24, 1966, that (I) (we) last saw the deceased alive on Mar. 24, 1966, and that death occurred at 12:15 from the causes and on the date stated above.									
22a. SIGNATURE				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)			
<i>A. E. Mance</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		24d. ADDRESS			
Dr. A. E. Mance				Oakland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		March 26/66		I.O.O.F. Cemetery		Elk Garden, W. Va.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<i>Amy Mildred Sharpless</i>				P.O. Kitzmiller, Md.		MAR 29 1966 <i>J. Charles Judge</i>			

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-256-

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY GARRETT CO MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MT. STORM, W.Va.						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland			c. LENGTH OF STAY IN 1b 8 DAYS 5HRS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MT. STORM 25-3						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GARRETT CO MEMORIAL HOSPITAL					d. STREET ADDRESS OAKLAND, MARYLAND			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WARNER			Middle HOLLEN		Last HANLIN		4. DATE OF DEATH 3/ MARCH		Day 8		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/2/88		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MT. STORM, W.Va.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOSEPH HANLIN					14. MOTHER'S MAIDEN NAME COSNER, SARAH						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mrs. Alice George. Mt. Storm. W.Va.			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C-V disease. DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (the hospital) attended the deceased from 2/27 1966, to 3/8 1966, that (I) (we) last saw the deceased alive on 3/8 1966, and that death occurred at 5:45A M, from the causes and on the date stated above.											
22a. SIGNATURE DR. E. I. BAUMGARTNER					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 3/9/66			
22c. PHYSICIAN'S NAME (Type) DR. E. I. BAUMGARTNER					22d. ADDRESS OAKLAND, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried			23b. DATE THEREOF 3/11/66		23c. NAME OF CEMETERY OR CREMATORY Mt. Storm Cemetery.			23d. LOCATION (City, town or county) (State) Mt. Storm. W.Va.			
24. FUNERAL DIRECTOR Leighton Durst					ADDRESS Leighton Durst Funeral Home, Oakland, Md.		25a. REC'D BY REGISTRAR MAR 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03793

03783

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W. VA.</b> b. COUNTY <b>PRESTON</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. LENGTH OF STAY IN 1b <b>2 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JESSIE WILT LANTZ</b>				4. DATE OF DEATH Month Day Year <b>MARCH 10 19 66</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 1, 1883</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <b>PRESTON, W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>JOHN WILT</b>				14. MOTHER'S MAIDEN NAME <b>SARAH ISABELLE STEMPLE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>NIECE-EDNA SLANTER-AURORA, W. VA.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>2 day</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Apr 1961</b> , to <b>MARCH 10, 1966</b> , that (I) (we) last saw the deceased alive on <b>MARCH 10, 1966</b> , and that death occurred at <b>8:55 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>						22b. DATE SIGNED <b>11 MAR 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. B. L. GRANT</b>				22d. ADDRESS <b>OAKLAND, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/13/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Aurora Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Aurora, West Virginia</b>	
24. FUNERAL DIRECTOR <b>[Signature]</b>				25a. REC'D BY REGISTRAR <b>[Signature]</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
DATE <b>MAR 15 1966</b>							



10789

10789



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03794					03784				
1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			c. LENGTH OF STAY IN 1b <b>44 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>					d. STREET ADDRESS <b>329 North Fourth Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Lowell</b> Middle <b>Arnold</b> Last <b>Loomis</b>		4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>19 66</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>July 6, 1901</b>		9. AGE (In years last birthday) <b>64 yrs.</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agent</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New Philadelphia, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Fordyce C Loomis</b>				14. MOTHER'S MAIDEN NAME <b>Daisy F Arnold</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-01-4581</b>		17. INFORMANT Address <b>(Brother)</b> <b>Cecil E. Loomis, Harrison, New York</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>URMIC SYNDROME - CEREBRAL EMBOLISM</b> <b>4201</b> DUE TO (b) <b>PULMONARY OEDEMA - ACUTE CARDIAL COLLAPSE</b> DUE TO (c) <b>RT. PULMONARY INFARCT - INTERIOR MYO CARDIAL INFARCT</b>								INTERVAL BETWEEN ONSET AND DEATH <b>47 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>3</b> p.m. <b>16</b> 19 <b>66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1/14/44</b> , 19 <b>44</b> , to <b>3/17</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3/16</b> , 19 <b>66</b> , and that death occurred at <b>1:03 AM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Dr. E. I. Baumgartner</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/17/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. E. I. Baumgartner</b>				22d. ADDRESS <b>226 E. Alder St. - Oakland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/18/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garr. Co. Mem. Gardens</b>		23d. LOCATION (City, town or county) (State) <b>Oakland, Md.</b>			
24. FUNERAL DIRECTOR <b>Leighton-Durst Funeral Home, Oakland, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03795 CERTIFICATE OF DEATH 03785

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gorman, W. Va.</u>	
c. LENGTH OF STAY IN 1b <u>22 Days</u>		d. STREET ADDRESS <u>Rt. # 1, Box # 7</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Garrett County Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Ellen</u> Last <u>Merrill</u>		4. DATE OF DEATH Month <u>March</u> Day <u>22</u> , Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10, 7/22/1881</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
12. BIRTHPLACE (County & State, or foreign country) <u>Garrett, Maryland</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>John DeWitt</u>		15. MOTHER'S MAIDEN NAME <u>Margaret Hawk</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. SOCIAL SECURITY NO. <u>None</u>	
18. INFORMANT (Daughter) <u>Mrs. Donald Moreland</u>		Address <u>Rt. #1, Gorman, W. Va.</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>22 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/18</u> , 19 <u>60</u> , to <u>March 22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>March 22</u> , 19 <u>66</u> , and that death occurred at <u>1:10 PM</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. A. E. Mance</u>		22b. DATE SIGNED <u>22 March 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. A. E. Mance</u>		22d. ADDRESS <u>Oakland, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/25/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Near Oakland, Md.</u>	
24. FUNERAL DIRECTOR <u>John O. Durr</u>		25a. REC'D BY REGISTRAR <u>MAR 28 1966</u>	
ADDRESS <u>Leighton-Durr Funeral Home, Oakland, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03796

03786

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Garrett</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> c. LENGTH OF STAY IN 1b <u>3 Years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cuppitt-Weeks Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>W. Va.</u> b. COUNTY <u>Mineral</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Keyser</u> d. STREET ADDRESS <u>109 Mozell St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
<b>3. NAME OF DECEASED</b> (Type or print) <u>Elinor</u> <u>Josephine</u> <u>Michael</u>		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>24</u> Year <u>1966</u>										
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>25 May, 1881</u>	<b>9. AGE</b> (In years last birthday) <u>84</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.										
Months	Days	Hours	Min.									
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Lexington, Iowa</u>								
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>												
<b>13. FATHER'S NAME</b> <u>George W. Ravenscroft</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Jennie Belle Dayton</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Dorthe Coatsworth</u> <u>Albuquerque, N.M.</u>								
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>331x</u> DUE TO (b) <u>ADVANCED ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (c)					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 week</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)										
<b>20c. TIME OF INJURY</b> Hour <u>19</u> e.m. p.m.	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)								
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4/9/63</u> <b>19</b> , to <u>3/24/66</u> <b>19</b> , that (I) (we) last saw the deceased alive on <u>3/21/66</u> <b>19</b> , and that death occurred at <u>1400</u> <b>PM</b> , from the causes and on the date stated above.												
<b>22a. SIGNATURE</b> <u>E. L. SAUINGARTNER</u>		<b>22b. DATE SIGNED</b> <u>1400</u>										
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>E. L. SAUINGARTNER</u>		<b>22d. ADDRESS</b> <u>OAKLAND - MD.</u>										
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>27 Mar. 1966</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Potomac Memorial Park</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Keyser, W. Va.</u>								
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Allen M. Kotnick</u>		<b>ADDRESS</b> <u>Keyser, W. Va.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u>								
		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		<b>DATE</b> <u>MAR 29 1966</u>								



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CERTIFICATE OF DEATH

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TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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<b>1. PLACE OF DEATH</b> a. COUNTY <u>Garrett</u> <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>408 E. Alder St.</u>				d. STREET ADDRESS <u>408 E. Alder St.</u>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>James</u> <u>Bernard</u> <u>Nally</u>				<b>4. DATE OF DEATH</b> <u>March</u> <u>5</u> , <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 27, 1905</u>			
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Loch Lynn, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Stevenson Nally</u>				14. MOTHER'S MAIDEN NAME <u>Cecila Reynold</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>220-03-7757</u>					
17. INFORMANT <u>Mrs. Faye Nally see # 2 above</u>				Address <u>see # 2 above</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic pulmonary disease</u> DUE TO (b) <u>Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> DUE TO (c) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH <u>10 1/2 yrs.</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>A. S. Mance</u>				22b. DATE <u>6 March 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>A. S. Mance</u>			
22d. ADDRESS <u>  </u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/7/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Garrett Co. Mem. Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Oakland, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Gerald N. Minnich</u>				ADDRESS <u>Oakland, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 10 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
03798													
1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>				c. LENGTH OF STAY IN 1b <u>5 days-20 hrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oakland McHenry</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Garrett County Memorial Hospital</u>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Pearle Buttermore Rhodes</u>			4. DATE OF DEATH Month Day Year <u>March 31, 1966</u>										
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 3, 1894</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Connellsville, Pa.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				
13. FATHER'S NAME <u>Albert J. Buttermore</u>						14. MOTHER'S MAIDEN NAME <u>Grace (None) Robinson</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-40-3069</u>		17. INFORMANT <u>Husband</u>		Address <u>Star Route Oakland, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADVANCED ARTERIO-SCLEROTIC</u> <u>4221</u> DUE TO <u>CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>66</u> , to <u>March 31</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>3/30/66</u> 19 <u>66</u> , and that death occurred at <u>6:50 PM</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Dr. E. I. Baumgartner</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. 22d. ADDRESS <u>226 E. Alder St. - Oakland, Md.</u>		22b. DATE SIGNED <u>3/31/66</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>April 3, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hill Grove Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Connellsville, Fayette Co., Pa.</u>					
24. FUNERAL DIRECTOR <u>John O. Hurst</u>						ADDRESS <u>Leighton-Hurst Funeral Home, Oakland, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03789

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b> c. LENGTH OF STAY IN 1b <b>17 DAYS 9 HRS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>THE GARRETT CO MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DEER PARK, Md.</b> d. STREET ADDRESS <b>Route #2,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ETTA</b> Last <b>RILEY</b>		4. DATE OF DEATH Month <b>3-</b> Day <b>27</b> Year <b>19 66</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/21/84</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		10. BIRTHPLACE (County & State, or foreign country) <b>PENNA</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>PENNA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SCOTT ROMESBURG</b>		14. MOTHER'S MAIDEN NAME <b>Peterman</b> <b>BUTCHER, SADIE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFIRMANT <b>MRS. TRIS R. PAUGH ( DAUGHTER)</b>		Address <b>Mt. Lake Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Thrombosis</b> 332x DUE TO (b) <b>Arteriosclerosis generalis</b> DUE TO (c) <b>diabetes mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>66</b> to <b>3/27</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>26 Mar</b> 19 <b>66</b> , and that death occurred at <b>4:50 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>29 Mar</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. B. L. GRANT</b>		22d. ADDRESS <b>OAKLAND, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/29/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Thayerville Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Near Oakland, Md.</b>	
24. FUNERAL DIRECTOR <b>John O. Durst</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		25c. DATE <b>MAR 30 1966</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03800					03790						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <b>Garrett</b> MARYLAND					a. STATE <b>W.Va.</b> Maryland b. COUNTY <b>Garrett</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Gormaniam Rural (W.Va.)</b> // - /							
c. LENGTH OF STAY IN 1b <b>1 day</b>				d. STREET ADDRESS <b>Route # 1</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Garrett County Memorial Hospital</b>											
3. NAME OF DECEASED (Type or print)			First <b>Viola</b>			Middle <b>Mae</b>			Last <b>Schrock</b>		
4. DATE OF DEATH			Month <b>March</b>			Day <b>2</b>			Year <b>19 66</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		IF UNDER 1 YEAR	
				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>Nov. 8, 1924</b>		<b>41</b> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Kempton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Sines</b>						14. MOTHER'S MAIDEN NAME <b>Nina Mae Simmons</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>268-30-3448</b>		17. INFORMANT (husband) <b>Gerald William Schrock</b>				Address <b>Route # 1 Gormaniam, W.Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> <b>7041</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Pyelonephritis, acute</b> DUE TO (c) <b>Phemphigus</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>48 hrs.</b> <b>12 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>"Cushing Syndrome" 20 to steroid therapy for 12 years for Phemphigus</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1954</b> , 19 <b>3-2-66</b> , 19 <b>3-2-66</b> , that <del>he</del> last saw the deceased alive on <b>3-1-66</b> <b>19 66</b> , and that death occurred at <b>7:15 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>James H. Feaster, Jr., M.D.</b>								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-2-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>James H. Feaster, Jr., M.D.</b>								22d. ADDRESS <b>Oakland, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3-4-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Garrett, Md.</b>			
24. FUNERAL DIRECTOR <b>Gerald D. Minnich</b>						ADDRESS <b>Oakland, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 10 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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STATE OF NEW YORK

IN SENATE  
JANUARY 10, 1933

REPORT  
OF THE  
COMMISSIONER OF THE  
DEPARTMENT OF  
CORRECTIONS

FOR THE YEAR  
ENDING DECEMBER  
31, 1932

ALBANY:  
J.B. LIPPINCOTT  
PRINTERS  
1933

MAR 10 1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03801 : CERTIFICATE OF DEATH										
03791										
1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park</b> c. LENGTH OF STAY IN 1b <b>8 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>614 "I" Street</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park</b> d. STREET ADDRESS <b>614 "I" Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Gertrude Glyndon Waters</b>					4. DATE OF DEATH <b>March 19, 1966</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 16, 1880</b>		9. AGE (In years last birthday) <b>85</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Bookkeeper</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Robinson Coal Co.</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Morgantown, W.Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Weslet Clark Waters</b>					14. MOTHER'S MAIDEN NAME <b>Emma Barbe</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Miss Louise Waters, Mt. Lake Park, Md.</b> Address <b>(Sister)</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extended sclerosis</b> <b>4500</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN DEATH AND DEATH <b>7045</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>18 Mar 66</b> to <b>19 Mar 66</b> , that (I) (we) last saw the deceased alive on <b>18 Mar 66</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above.										
22a. SIGNATURE <b>A. E. Mance</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>20 Mar 66</b>			
22c. PHYSICIAN'S NAME (Type) <b>A. E. Mance, M.D.</b>					22d. ADDRESS <b>Oakland, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 21, 66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maple Grove Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Fairmont, W. Va.</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leighton-Burst</b> ADDRESS <b>Leighton-Burst Funeral Home, Oakland, Md.</b>					25a. REC'D BY REGISTRAR <b>MAR 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03802

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03792

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>12 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett Co. Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles Issac Wright</b>		4. DATE OF DEATH <b>March 8th. 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25, 1884</b>
9. AGE (In years last birthday) <b>82</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
13. BIRTHPLACE (State or foreign country) <b>Garrett Co., Md.</b>		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. FATHER'S NAME <b>William Wright</b>		16. MOTHER'S MAIDEN NAME <b>Jane Harvey</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>19 66</b>	
19. INFORMANT <b>Mrs. C.I. Wright, McHenry, Md.</b>		Address (Widow)	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation, acute</b> 4221 DUE TO <b>Arteriosclerotic cardio-vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Years</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Frat. right hip 2-24-66 with open reduction 2-25-66</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <b>Fell out of bed at home 2-24-66</b>	
20c. TIME OF INJURY Month, Day, Year <b>2 p.m. 2-24-66 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>McHenry, Garr. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>3-8-66</b>	
ACTUAL SIGNATURE <b>James H. Feaster, Jr., M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>Oakland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Mar. 11, 66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>George Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Near Swanton, Md.</b>
24. FUNERAL DIRECTOR <b>John O. Durst</b>		25a. REC'D BY REGISTRAR <b>MAR 11 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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